Health Care Financing Administration

ANNUAL REPORT 1999

HCFA
Health Care Financing Administration

Health Care Financing Administration
1999 Annual Report

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INTRODUCTION

We in the Health Care Financing Administration (HCFA) have been entrusted by the American people with an awesome set of responsibilities. We are the largest purchaser of health care in the United States — our programs account for more than one third of the dollars spent on health care in the U.S. economy and comprise the third largest outlay of the Federal Government, behind only Social Security and interest on the national debt. We provided health care coverage in 1999 for almost 70 million people — nearly one out of every four Americans. We run the Medicare program, providing health care security and choice for aged and disabled people in this country. Jointly with State governments, we run the Medicaid program and the State Children's Health Insurance Program (SCHIP), guaranteeing access to health care for America's vulnerable and poor populations. We regulate clinical laboratory testing, help to regulate the private health insurance market, and promote health care quality through survey and certification of health care facilities such as nursing homes and home health agencies.

These activities are performed with one thing in mind: a commitment to the people who rely upon our programs for the access to and quality of the health care they need. Our mission, though complex in execution, is simply stated: We assure health care security for beneficiaries. And our vision is no less ambitious: In the stewardship of our programs, we lead the Nation's health care system toward improved health for all.

To carry out our responsibilities, HCFA maintains its headquarters in Baltimore and Washington DC, as well as 10 regional offices nationwide. Without the dedication, expertise, and experience of the 4,600 full- and part-time employees of the agency, none of the accomplishments described in this report could have happened. I am proud and honored to be associated with this exceptional group of people.

As tireless as is HCFA's workforce, however, it could never accomplish all our mission operating alone. We work in partnership with many other organizations and individuals: other Federal and State agencies and Territorial and Tribal governments; private-sector contractors; health plans, practitioners, and health care facilities; professional organizations, academia, and advocacy groups; and beneficiaries and their families.

Working together, we have amassed some impressive statistics. In 1999:

* Through our contractors, we processed 866 million Medicare claims, including 144 million paper claims.
* We made monthly payments to as many as 310 risk-bearing HMOs covering the care of 6.2 million Medicare enrollees.
* Our contractors responded to 16 million beneficiary inquiries and 23 million provider inquiries, most of which were

made by telephone. We handled another 1.8 million inquiries received via our Internet Websites.

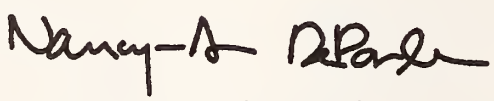
* We adjudicated 20,000 Medicare managed care appeals made by enrollees, reviewed more than half a million appealed fee-for-service claims, and conducted more than 120,000 hearings on appealed claims.

* Together with the States, we drew nearly 2 million children into SCHIP programs around the country.

* We continued to implement the more than 300 provisions of the Balanced Budget Act of 1997 (BBA), as well as the more than 130 provisions of the Balanced Budget Refinement Act of 1999 (BBRA) that affected our programs — activity that carried over into this year as well.

But as impressive as they are, numbers don't tell the real story. The real story is our service to today's beneficiaries and the ways in which we discharge our responsibility to future beneficiaries.

The chapters that follow show how we addressed the needs of our beneficiaries in 1999, while maintaining our fiduciary responsibility to America's taxpayers. They also show the challenges we face in continuing to improve our performance and responsiveness.



Nancy-Ann Min DeParle

Administrator

Assuring the Continuity of Our Programs: Meeting the Y2K Challenge

HCFA's risk from Y2K exposure — the threat to computer programs' stability as the clock turned over to January 1, 2000 —was potentially higher than that of many other Federal Government agencies. As the largest health insurer in the Nation, our actions have an impact on the entire health care industry. Congressional Y2K Committees and the General Accounting Office charged HCFA with a health care readiness role broader than Medicare and Medicaid, and published analyses and "readiness grades" for the health care sector and HCFA.

The agency faced a daunting challenge. We had to check more than 150 computer systems, containing some 50 million lines of code, to make sure that they would work after December 1999. And those figures do not take into account the systems used by health care providers, banks, and State Medicaid programs in their interactions with us.

Because of our efforts and those of our partners, HCFA's systems entered the Year 2000 with virtually no Y2K problems or disruptions. As expected, all of our Medicare systems operated properly, as did the systems of managed care organizations (MCOs) and State Medicaid agencies.

The time and resources expended to prepare our systems and those of our partners for the Y2K rollover have produced lasting benefits. Thanks to this work, our Medicare systems are in better shape now than they have ever been. We have also gained experience in overall business planning and operational assessments. And the experience has enabled all of us to learn new tools and methodologies and to apply these techniques to other systems challenges.

System Testing

The New Year's weekend was the culmination of almost two years of intense work by hundreds of employees and contractors. We had to assure the Y2K readiness of all the systems that process Medicare fee-for-service claims, pay bills, manage the eligibility, enrollment, and premium status of Medicare beneficiaries, and make payments to managed care organizations. We also assessed the readiness of and provided technical assistance to Medicaid State agencies and MCOs as they renovated their own computer systems.

Testing, Certification, and Recertification Activities. All of HCFA's internal systems were renovated, tested fully, certified compliant, and implemented prior to January 1, 2000. The testing was the most extensive and rigorous ever conducted on our systems, and an Independent Validation and Verification (IV&V) contractor, with oversight from the Department of Health and Human Services (DHHS) Office of Inspector General (OIG), verified the readiness of our external contractor systems.

HCFA Oversight and Monitoring of Contractor Y2K Activities. Beginning in the fall of 1998 and continuing long past

January 1, 2000, we conducted an intensive monitoring effort of each Medicare contractor or systems maintainer's test progress, using a combination of onsite personnel, document reviews, performance and quality metrics, periodic teleconferences, and oversight by our IV&V contractor as well as by the OIG.

Contingency Planning and Day One Activities. HCFA and each of the contractors created and tested detailed backup plans that could be quickly put into place if a Y2K problem occurred. HCFA also placed representatives onsite at each contractor and standard system maintainer during "Day One" — the January 1 rollover period — to monitor the continuity of Medicare business operations and to make certain any problems were identified, reported, and fixed quickly.

Provider Outreach

A major component of HCFA's Y2K initiative was outreach to health care providers. We needed to assure them that HCFA was ready for January 1, but that providers needed to be sure that they could file Y2K-compliant Medicare and Medicaid claims. That meant that in addition to their claims software, providers needed to confirm the readiness of their other business systems, their facility infrastructure and their equipment for patient diagnosis and treatment. HCFA's unprecedented provider outreach activities included approximately 85 national conferences and local learning sessions; direct mail campaigns; web technology; a toll free Provider Y2K Information Line; media advertising; and technology tools. We worked closely with other government departments involved in Y2K outreach to the health care community, including the Food and Drug Administration, the Department of Veterans Affairs, the Small Business Association, and the National Institute of Standards and Technology.

Reaching Out to Medicare Beneficiaries: The National Medicare Education Program

Today's Medicare has more to offer beneficiaries — more preventive benefits, new patient protections, more information, and more help with questions. To help beneficiaries take the fullest advantage both of new benefits and of new program flexibility, we undertook the largest and most complex educational effort in the history of Medicare. The National Medicare Education Program (NMEP), developed with broad-based input from beneficiary advocates, other payers, insurers, and academics, will ensure that beneficiaries receive accurate, easy-to-understand information about their benefits, rights, and health insurance options so they can become more active participants in their health care decisions.

The success of our efforts is reflected in consumer satisfaction ratings. In 1999, HCFA was one of 29 Federal agencies that participated in the U.S. Government Customer Satisfaction Initiative. Expansion of the American Customer Satisfaction Index (ACSI) to measure satisfaction with those agencies provides the first cross-agency measure of customer satisfaction with Federal services. HCFA received an overall satisfaction rating of 71, comparable to the ACSI index for private service sectors of 71.9 and the aggregate score of 68.6 for the Federal Government. Individual Federal agency ratings ranged from 51 to 87, comparable to ratings of 53 to 86 in the private sector.[1]

Beneficiaries surveyed — a sample of enrollees who had a claim for Part A services during 1998 — rated the ease of Medicare enrollment very highly (our score was 88), as well as the courtesy and professionalism of Medicare staff (we scored 85), and reported that their actual experience with Medicare surpassed their expectations. The satisfaction rating for accessability and usefulness of Medicare information (73) was similar to the overall service sector rating, but suggests an area where we should focus our attention in the future.

Facets of the NMEP

Print Materials. Based on the 1998 pilot test in five States (Arizona, Florida, Ohio, Oregon, and Washington), we mailed an updated *Medicare & You* handbook to all beneficiary households in the fall of 1999 — one of the most massive mailings in the history of the U.S. Postal Service.

We evaluated *Medicare & You* with surveys, focus groups, expert review (including reviews by low-literacy experts), and cognitive interviews. Among the results of our evaluation, we found that four out of five enrollees surveyed thought the Handbook was "fairly easy" or "very easy"

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[1] The full report on the American Consumer Satisfaction Index can be found at http://www.customersurvey.gov/index.htm.

to understand, and that 64 percent of respondents were satisfied or very satisfied with the Handbook. Focus group respondents liked the section of *Medicare & You 2000* that provided local information, but many beneficiaries did not notice the section when they received the Handbook.

Internet Activities. Internet access among Medicare enrollees who are 65 and older skyrocketed from 6.8 percent in 1997 to 21.3 percent in 1999. Industry figures on Web use indicate that people over the age of 50 represent the largest and fastest growing population on the Internet. They are increasingly using computers and the Internet to search for information on vital issues like health care.

In response, HCFA launched a beneficiary-friendly Website, www.medicare.gov, early in 1998. The award-winning site includes *Medicare & You*, lists of resources for beneficiaries and people who work with beneficiaries, general information about Medicare, and detailed comparisons of the benefits and costs of plans available in communities. Consumer satisfaction surveys and standardized performance measurement systems of available managed care plans were added to the site early in 1999. One of the most frequently-visited areas in this Website offers detailed information about individual nursing homes around the country.

Most users find www.medicare.gov user-friendly. We logged a little more than 10 million page views on the site in 1999, and currently register 1.3 million page views per month. More than 90 percent of users filling out the on-line evaluation form indicated that the site was easy to use, and 85 percent indicated that the site contained useful information. Visually impaired focus group participants thought www.medicare.gov was well designed for use with assistive technology.

Toll-Free Telephone Service. A toll-free Helpline, 1-800-MEDICARE, became operational in November 1998 in the five pilot States, and by March 1999 it had become operational nationwide. Telephones are staffed by customer service representatives from 8 a.m. to 4:30 p.m. local time, Monday through Friday. At other times, the telephone line offers pre-recorded information, providing for service 24 hours a day, 7 days a week. An analysis of the calls received showed that the average call length is five minutes, and that most calls focus on Medicare+Choice (M+C) options, Medicare benefits, enrollment, replacement cards and coverage issues.

To evaluate the Helpline, we conducted "mystery shopping" calls. Evaluators contacted the Helpline, posing as either a beneficiary or as a friend or family member of a beneficiary. They asked specific questions and collected information on customer service, completeness and accuracy of answers, and referrals offered. The answers for 96 percent of the calls were rated as understandable by the mystery shoppers, and the overall courteousness of the customer service representatives was rated high. Over time, the completeness of answers to questions has improved, but there remains variation across customer service representatives in terms of how they answer specific questions.

We also re-contacted Helpline callers to ask about their calling experience. Generally, 83 percent of callers contacted were "satisfied" or "very satisfied" with the

Helpline. Although the majority of callers rated specific characteristics of the Helpline as very good or excellent, about 10 percent of them rated as "fair" or "poor" their experience getting the information desired and the thoroughness of the Helpline's knowledge of Medicare options. Regarding the automated system, 56 percent of respondents found it easy to use, and 22 percent found it confusing.

National Alliance Network. We have enlisted national and local partners to support and participate in the NMEP. More than 200 national and local organizations that work on behalf of aged and disabled Americans are involved in this public-private partnership.

We have conducted interviews and focus groups to obtain feedback from National Alliance Network partners regarding what has worked well in terms of the partnership and areas in need of improvement. Feedback also is being obtained from a bounceback form that has been placed on the partners' Website to encourage systematic feedback about the site. To date, 92 percent of people responding to the form have rated the site as mostly or entirely useful, and close to 90 percent feel the site is easy to use.

Enhanced Beneficiary Counseling from State Health Insurance Assistance Programs. State Health Insurance Assistance Programs (SHIPs) are key partners in the NMEP. These organizations are part of each State's Office on Aging or Office of Insurance. Extensive training has been conducted with SHIPs to prepare them to help Medicare beneficiaries make informed decisions about their health care.

Assessment activities included interviews with all SHIP directors, monitoring changes in volume and content of counseling sessions, and beneficiary survey questions. Eighty-five percent of those who received counseling (SHIP and other sources of counseling combined) were "very satisfied" or "satisfied" with the service. The monitoring work to date points to the need to develop standard performance measures to assess and evaluate the activities and effectiveness of the SHIPs. Revised performance measures have been identified and pilot tested, and are in the process of being implemented nationwide.

National Train-the-Trainer Program. Seven hundred people from HCFA partner organizations across the country have received training about M+C and other program changes. The goal of the training is to give trainers the information and tools to teach others in their organizations and communities how to help beneficiaries understand their options. Almost all participants in the training sessions conducted for the 1999 campaign felt that the training modules were either useful or very useful, with ratings averaging 4.28 or better on a 5-point scale.

Regional Education About Choices in Health (REACH). Each of HCFA's 10 regional offices is conducting educational and outreach efforts at the regional, State and local levels. Many of these activities target special populations such as minorities, care givers, beneficiaries who are eligible for both Medicare and Medicaid, and rural beneficiaries. Part of this outreach includes public presentations and exhibits at local health fairs and other health-related events.

A wealth of data has been collected through direct observation of activities, interviews using structured protocols, and

interviews with attendees of events to establish a baseline for performance measurement and to analyze activities and best practices. Beneficiaries respond very positively to presentations, but relatively few are contacted by this activity. The attendance at health fairs is variable; sometimes the expected attendance is very low. However, more than 85 percent of beneficiaries who attended presentations or health fairs were satisfied with the events.

Targeted and Comprehensive Assessment of Education Model. Because the NMEP is a new effort, we have developed an extensive evaluation and monitoring strategy. Based on our evaluation, we are studying ways to improve the delivery of information to beneficiaries.

During 1999, we began a comprehensive assessment of the five-State pilot education program, including message testing and focus group sessions with Medicare beneficiaries in those States. Six case studies — in Dayton, OH; Eugene, OR; Olympia, WA; Sarasota, FL; Springfield, MA; and Tucson, AZ — were initiated, including interviews and focus groups with key informants and beneficiaries, to track the evolution of the NMEP and to identify "best practices" that could be used in other areas.

There is evidence from the case study sites that many beneficiaries lack a basic understanding of the Medicare program. We found that nearly one in five of beneficiaries surveyed were not familiar with the term "managed care plan," "HMO" or "health maintenance organization," even though managed care does exist in each of these communities. On the other hand, almost half of beneficiaries know that if you join an HMO, you do not have to leave the Medicare program, and about a third know that HMOs can raise their fees or change their benefits every year.

We have gained valuable insights through our evaluation. We found that beneficiaries primarily seek information when a specific need arises, and often are not responsive to information supplied at other times. Medicare information needs to be targeted to specific populations, or to populations coping with specific situations — such as newly enrolling in Medicare, termination of a health plan, loss of a spouse, or an important health event.

To monitor the overall education effort, we are using the Medicare Current Beneficiary Survey, a nationally-representative survey of some 16,000 beneficiaries. Through this survey we are tracking over time the ability of beneficiaries to get Medicare information when needed, their awareness of basic Medicare messages, and their perceived level of knowledge. Data collected in the winter 1999 round of interviews suggest that 67 percent of beneficiaries had their Medicare questions answered by the information that they received through Medicare information sources. But when asked, "How much do you feel you know about the availability and benefits of Medicare managed care plans," only 25 percent replied, "I know everything or most of what I need to know."

Funding the NMEP

Funding for the NMEP has grown. In FY1998, we had spent approximately $95 million on the pilot phase of the campaign. We spent approximately $137.3 million in FY1999 on the national implementation — about $3.50 per Medicare beneficiary. That expenditure covered the costs of the national

handbook mailing and a variety of brochures and pamphlets about Medicare+Choice and Medicare, 1-800-MEDICARE, www.medicare.gov, community-based outreach, promotion and publicity, social marketing, training, and the Consumer Assessment of Health Plan Study (CAHPS) surveys. In FY1999, 66 percent of the funds came from M+C plan user fees, 28 percent came from program management funding, and 6 percent from the Peer Review Program apportionment.

For a complete report on the early evaluation of the NMEP, visit our Website http://www.hcfa.gov/ord/resrpub.htm.

The Citizens Advisory Panel on Medicare Education

To help inform, shape and improve HCFA's policies and strategies for educating beneficiaries about the features of the Medicare+Choice program, we created the Citizens Advisory Panel on Medicare Education in 1999.

The Panel meets quarterly to help HCFA:

* support the NMEP;
* enhance the Federal Government's effectiveness in informing Medicare consumers;
* expand outreach to vulnerable and under-served communities;
* assemble an information base of "best practices" for helping consumers evaluate health plan options.

Additional information about the Panel is available at its Website: http://www.hcfa.gov/fac/apmepage.htm.

Upholding Our Fiduciary Responsibility to America's Taxpayers: Fighting Fraud, Waste, and Abuse in Medicare and Medicaid

Programs such as ours require extensive and continued vigilance. Although the vast majority of those who interact with us are honest and the vast majority of claims filed are appropriate, the sheer volume of business and the complexity of our programs create an enormous potential for inappropriate payments. The fiscal integrity of Medicare and Medicaid are critical factors in public confidence in those programs.

During 1999, we continued and expanded work in a number of areas of fiscal integrity.

Program Safeguard Contractors (PSCs). Using our authority under the Medicare Integrity Program (MIP), HCFA awarded contracts to 13 prime PSCs eligible to compete on task orders we issue associated with the payment safeguard functions of medical review, cost report audit, data analysis, provider education, and fraud detection and prevention. Six task orders were awarded during 1999:

* data analysis to minimize risk of increased fraud and abuse surrounding millennium uncertainty;
* developing a focused data analysis center to support fraud unit activity in the New England states;
* unannounced site visits by mental health professionals to assess community mental health centers applying to, or providing services to, the Medicare program;
* performing on-site reviews of providers subject to Office of Inspector General Corporate Integrity Agreements;
* provider outreach and education relating to program integrity efforts;
* conducting field audits on the home offices of large chain facilities.

Coordination of Benefits. On average, Medicare saves roughly $3 billion annually by ensuring that private insurance companies pay their share of Medicare beneficiaries' health care bills. Termed coordination of benefits (COB), these activities have historically been performed by a variety of contractors, yielding somewhat inconsistent results. As part of the MIP, in 1999 we established a single national COB contractor to coordinate Medicare payments with other insurance companies by collecting, managing and reporting claims information.

Better oversight of contractors conducting program integrity work. As part of our effort to ensure consistency and to focus on key contractors and high-risk areas, standardized contractor performance evaluation protocol were implemented to gauge contractors' success in meeting core standards in the areas of benefit integrity, medical review, and provider and supplier enrollment.

Outreach and education to providers about program integrity. Under the MIP program, a task order focusing on provider education about the Medicare program was issued. The anticipated outcomes from the task order include enhancing provider knowledge and understanding of Medicare program requirements; increasing the accuracy in submitting claims correctly the first time; and providing the necessary tools and knowledge required for providers to properly bill the Medicare program.

Overpayment collection improvements. Overpayment collection improvements include work on legislative proposals around bankruptcy laws, the use of petition of remission, improved guidance on voluntary refunds, payment suspension, and the use of statistical sampling in overpayment estimation. We continue to strive toward accurate assessments and just corrective remediation to address improper billing situations.

Technology assessments of anti-fraud tools. We contracted with an information technology firm to create a survey instrument to catalog the functionality of commercially available electronic fraud, waste, and abuse detection products. The survey instrument marks the first step in a process that ultimately will permit us to conduct full technology assessments of these tools.

Payment Error Prevention Program (PEPP). The Payment Error Prevention Program, or PEPP, is a new effort begun in 1999 to use the Peer Review Organizations (PROs) to increase their focus on ensuring that Medicare hospital inpatient claims are billed and paid appropriately. Under the PEPP, the PROs will develop a monitoring system to continuously estimate the payment error rate independently within each State, or PRO area. PROs will be required to conduct analyses to identify the nature and extent of payment errors occurring in their area, and use this information to develop interventions, ranging from education to referral to law enforcement, aimed at changing provider behavior and decreasing the observed payment error rate.

We have been equally active in combating fraud and abuse in the Medicaid program.

Medicaid fraud statutes Website. This site lists the best Medicaid anti-fraud and abuse citations of State statutes used to prosecute criminal or civil fraud and can be found at http://www.hcfa.gov/fraud/mfs.

Medicaid fraud and abuse executive seminars. We sponsored a series of seminars directed at State decision-makers, but participants also included representatives from OIG, FBI, and other Federal agencies.

Guidelines for addressing fraud and abuse in Medicaid managed care. This document provides ideas and guidelines to assist preventing, identifying, investigating, reporting and prosecuting fraud and abuse in capitated managed care programs. It also provides new measures and strategies to meet such goals.

Review of State program integrity procedures by national review team. The primary purpose of these reviews is to determine whether State agencies are complying with appropriate laws and regulations.

Coordination with the Office of Inspector General (OIG). We continue to work closely with the OIG. Results that have been

achieved in the past year include the release of two State Medicaid letters relating to excluded providers and managed care regulation issues.

National Fraud Investigation Database. We are currently working to modify this nationwide database to capture Medicaid fraud cases as well as Medicare cases.

For more information on HCFA's efforts to prevent fraud and abuse, visit our Website at http://www.hcfa.gov/medicare/fraud/default3.htm.

Ensuring the Soundness of Our Programs: Financial and Management Reforms

HCFA's programs — Medicare, Medicaid, and SCHIP — are providing more coverage, more health plan options, and more health care security to America's most vulnerable populations than ever before. But new flexibilities pose new management challenges, and in 1999 we continued or undertook a variety of initiatives designed to strengthen our ability to meet those challenges.

Chief Financial Officer (CFO) Report

In FY1999, we made significant improvements in financial management at HCFA. Prudent financial management is important in any situation, and as an agency with one of the largest budgets in the Federal Government, we in HCFA have a special obligation to ensure that we spend each dollar, whether for benefits or administration, as wisely as possible.

Our most notable achievement in FY1999 was obtaining the first clean audit opinion on our financial statements. During the year we performed extensive analysis of our accounts receivables, and we implemented a number of changes in the reporting of delinquent debts in order to reflect accounts receivables at their true economic value.

Although we received a clean opinion on our financial statements, our auditors continue to have internal control concerns with many aspects of contractors' accounts receivable, stemming from the lack of a fully integrated contractor-based general ledger accounting system. We share this concern, and our long-range plan is to evaluate strategies for an integrated general ledger accounting system for all Medicare contractors. Until then, we anticipate extra efforts will be necessary to support accounts receivable.

We continue to make important accomplishments in other financial areas as well.

* We redesigned Contractor Performance Evaluation reviews to include the development of clear and measurable performance standards by moving toward a national review process with greater consistency.
* We continued implementation of the HCFA Travel System. All regional offices have been trained on the travel system and are operational.
* We released our first Comprehensive Plan for Program Integrity, to highlight HCFA's goals and overall strategy for reducing payment errors in the Medicare and Medicaid programs. The DHHS OIG has reported that the Medicare fee-for-service payment error rate for FY1999 was 7.97 percent, or $13.5 billion. This error rate is what the OIG called elsewhere a "remarkable improvement" from FY1996, when the national error rate was first calculated and found to be in excess of 14 percent. We will continue to focus additional

efforts and corrective actions to achieve our goal of reducing the error rate for all Medicare fee-for-service payments to 5 percent by FY2002. The complete Comprehensive Plan for Program Integrity is available at http://www.hcfa.gov/medicare/fraud/intro.htm

GOVERNMENT PERFORMANCE AND RESULTS ACT OF 1993 (GPRA)

HCFA's Annual Performance Plan (APP) sets our specific performance goals for the Agency for the fiscal year. GPRA requires Federal agencies to prepare 5-year Strategic Plans setting out long-term goals and objectives. It also requires APPs that link the Strategic Plan with the annual budget request by committing to short-term performance goals, and Annual Performance Reports explaining and documenting how effective the agency's actions have been in achieving these goals.

The FY2001 budget request contained the first Annual Performance Report with our FY1999 goals. Data are now available for 16 of our 18 goals, and we were able to report positive results during our first reporting year. We were successful on 12 goals:

* We ensured millennium compliance of our computer systems;
* We achieved a clean audit opinion of our financial statements;
* We reduced the Medicare payment error rate;
* We decreased the use of restraints in long-term care facilities;
* We reduced Medicare home health payment errors;
* We increased the use of electronic commerce in Medicare;
* We provided States with dual eligible data;
* We implemented a strategy to increase health care access for dual eligibles;
* We developed a Medicaid childhood immunization goal;
* We developed a goal to decrease the number of uninsured children;
* We developed targets for Medicare beneficiary satisfaction; and
* We developed a goal to assess research investments.

We were not completely successful for 4 of our goals, but made significant progress on them:

* We did not meet our target percentage of Medicare beneficiaries with at least one managed care option;
* We made significant improvements but fell just short of our targets for laboratory test accuracy;
* Y2K activities delayed our implementation of outpatient prospective payment systems; and
* We did not achieve our goal for timely enrollment of beneficiaries under the Medicare+Choice program.

We are still awaiting final data for two goals (increasing annual influenza vaccination rates and biannual mammography rates for Medicare beneficiaries), but we anticipate success based on secondary data sources.

HCFA's FY2001 APP, available at http://www.hcfa.gov under the category of "Statistics and Data," reflects our continued efforts to strengthen coordination with other organizations and to enhance data verification and validation. We have carried over the majority of the goals in the FY2000 plan, with new targets appropriate for FY2001, and we have expanded the plan to further represent important Agency initiatives.

HCFA MANAGEMENT REFORMS

In FY1999, total operating costs for the Medicare program were approximately 1.8 percent of total Medicare benefit outlays, and total actual Federal and State administrative costs were approximately 5 percent of Medicaid benefit outlays.[2] In part, these low rates are attributable to efficient management, economies of scale, and the nature of our markets. During 1999, we focused not only on the most efficient use of administrative resources available to us, but on proposals to improve our ability to operate our programs, to better serve beneficiaries, taxpayers, and the doctors, hospitals and other providers of health care.

New private sector and medical expertise. During the past year, HCFA has successfully recruited people with recent experience in the fast-changing health care marketplace. We also recruited people with industry experience in new Medicare coverage options like managed care.

Management reform initiative. Building on its previous activities to improve accountability and focus on results, the Administration proposed in 1999 a management reform initiative to provide needed flexibility to HCFA's operation. That proposal provides for enhanced personnel, pay and procurement flexibility to help make sure the agency can hire the right staff and outside contractors to do the job. It also provides for improved program flexibility. We will evaluate new authorities and make greater use of existing authorities to pay for services at market rates, enter into selective contracts, and engage in competitive bidding.

Structural reform. We have begun to reengineer the relationship between HCFA's central and regional offices by instituting policies to assure greater consistency in oversight and enforcement activities across regional offices in such areas as nursing home survey and certification and managed care plan certification.

CONTRACTOR REFORM

The Administration has asked Congress to enact contracting reform legislation to allow HCFA to move to more competitive and effective procurement with the contractors that process Medicare claims. This effort would bring Medicare into conformance with Federal acquisition regulations and relieve us from the onerous contracting provisions contained in Title XVIII of the Social Security Act.

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[2]This figure is based on "fully-loaded" operating costs, including HCFA's discretionary Program Management appropriation, all Health Care Fraud and Abuse Control account (HCFAC) funding, Peer Review Organization (PRO) funding, and slightly more than $1 billion in non-HCFA administrative costs expended by the Social Security Administration and other Federal agencies.

We also introduced internal reorganization to strengthen management of third party Medicare fee-for-service contractors. We established a Medicare Contractor Oversight Board, comprised of senior agency leaders, to provide tactical and strategic guidance for contractor management. We also created a senior leadership position for contractor management — the Deputy Director for Contractor Management in the Center for Beneficiary Services (CBS). And we established a new Medicare Carrier and Intermediary Management Group within CBS to serve as the HCFA lead for all Medicare fiscal intermediaries and carrier programmatic and operational issues.

In addition to these organizational changes, we have taken aggressive steps since 1998 to strengthen our oversight of the private insurance companies that, by law, we must use to process and pay Medicare claims.

Developing contractor-specific error rates. We are developing error rates to measure and track the payment accuracy for each claims-processing contractor. The results will help us measure contractors' progress reducing errors much as the Inspector General's national Medicare error rate has guided HCFA's improvement efforts.

Requiring corrective action plans. We have directed the private insurance companies that process claims to develop and implement corrective action plans immediately following their annual evaluations to ensure that they can track funds more accurately.

Creating a new national performance evaluation strategy. In May 1999, we implemented a new strategy to ensure consistency and to focus on key contractors and high-risk areas. We are developing additional defined, measurable standards to support more targeted and consistent reviews of specific areas of contractor performance.

Using national teams to review performance. In 1999, we created national review teams to evaluate contractors' fraud and abuse efforts and other key functions, using standardized reporting and evaluation protocols.

Placing additional financial managers at contractor sites. The President's FY2001 budget includes more than $40 million in additional funds to support contractor management and oversight, including new positions at the contractors to tighten financial controls and ensure a swift, coordinated response to waste, fraud and abuse.

PROTECTING THE HEALTH OF AMERICA'S CHILDREN: IMPLEMENTING THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP)

Created by the Balanced Budget Act of 1997, the State Children's Health Insurance Program (SCHIP) was designed to reach about 5 million of the nearly 11 million children in America who were uninsured for medical care — many of whom came from working families with incomes too high to qualify for Medicaid but too low to allow them to afford private health insurance.

SCHIP is a partnership between the Federal and State governments. Approximately $39.6 billion of Federal money is set aside through FY2007 for States to provide new health coverage for children. By statute, the amount allotted to States for SCHIP activity in FY1999 was $4.247 billion — about the same as the $4.235 billion allotted in FY1998. Under the new program, States have flexibility in the design of their programs and how they choose to target eligible uninsured children. States may choose to expand their Medicaid programs, design new child health insurance programs, or create a combination of both.

PRIORITIES AND ACCOMPLISHMENTS IN 1999

Nearly two million children who would otherwise be without health insurance coverage were enrolled in SCHIP in FY1999 — double the number reported for the first full year of the program. Of the 56 approved State and U.S. territorial children's health insurance programs, 53 were implemented and operational during FY1999. By the end of December 1999, we had approved 36 State plan amendments, many of which expand SCHIP eligibility to even more children. Several of these amendments were in effect during FY1999, and many more will be implemented in the coming months, providing health insurance to even more children. The complete SCHIP annual enrollment report for FY1999 is available at http://www.hcfa.gov/init/children.htm.

Activities to implement SCHIP in 1999 involved an unprecedented coalition of Federal, State, and private organizations, working together to reach out to families whose children qualify for coverage.

Public-Private Collaboration to Insure Kids Now!

In February 1999, the President launched the Insure Kids Now outreach campaign:

A new toll-free number. The National Governors' Association established 1-877-KIDS NOW, a national toll-free number that directs families anywhere in the nation to their own State Children's Health Insurance information hotlines. From February through December 1999, more than 224,000 calls were automatically directed to State hotlines.

Insure Kids Now Web Site. In 1999, we created http://www.insurekidsnow.gov, a Web site with eligibility and contact information for each State, territory and the District of Columbia. It also contains information about

local and national outreach activities, including school-based outreach.

Promoting the Insure Kids Now Campaign. From February to June 1999, DHHS sponsored a national radio advertising campaign to promote the 1-877-KIDS NOW toll-free number and to complement States' outreach efforts. The President also announced unprecedented new efforts from the private sector — specifically television, radio, and print organizations — who pledged to promote the Insure Kids Now toll-free number .

Supporting the Insure Kids Now Campaign. The Federal Interagency Task Force on Children's Health Insurance Outreach, comprised of more than 10 Federal agencies, prepared an outreach training kit for use by workers from all Federal departments that participate in the Insure Kids Now campaign, in concert with the national toll-free number for children's health insurance outreach.

School-Based Outreach Efforts

Back-to-School Campaign. The Department of Health and Human Services, along with the Department of Justice, the Department of Education and 17 national nonprofit organizations including the United Way, coordinated back-to-school enrollment activities in 25 communities nationwide, in conjunction with the radio advertising campaign. The Back-to-School campaign was supported by several national non-profit organizations.

Presidential Directive to Develop Strategies to Integrate Children's Health Insurance Outreach into Schools. In October 1999, the President signed an executive memorandum instructing the Secretaries of DHHS, Education, and Agriculture to report to him in 6 months on steps the Federal Government can take to institutionalize school-based outreach and enrollment, and to highlight successful ongoing programs.

OTHER PROGRAM HIGHLIGHTS FOR 1999

The activities described above all took place in the context of our ongoing administration of the programs entrusted to us by the American people. Perhaps not as visible or as immediate as the "hot" topics, it is in the day-to-day discharge of that administration that HCFA fulfills its mission.

PROVIDING HEALTH CARE SECURITY AND CHOICE FOR AMERICA'S SENIORS AND PEOPLE WITH DISABILITIES: MEDICARE

Medicare is the health insurance program created in 1965 by Title XVIII of the Social Security Act. It currently covers many of the health care costs for more than 39 million Americans who are either 65 years of age and older, too disabled to continue working, or suffering End-Stage Renal Disease (permanent kidney failure treated with dialysis or a transplant). Medicare's Board of Trustees reported that in FY1999, Medicare paid $208 billion for health care goods and services provided to its enrollees, and another $2.9 billion to administer the program.[3]

Beneficiary choice is a hallmark of the Medicare program. The Original Medicare Plan (fee-for-service) is available everywhere in the United States, and is the way most people get their Medicare benefits. Enrollees may go to any doctor, specialist, or hospital that accepts Medicare. They pay their copayment or coinsurance (or have their secondary insurer billed), and Medicare pays its share directly to the provider of care. Fee-for-service enrollees have the full range of covered services available, but — by law — some services, notably most outpatient prescription drugs and long term care, are not covered.

Through the M+C program, beneficiaries in certain areas of the country can choose to receive their health services through organizations under contract with HCFA to provide Medicare covered services to beneficiaries who enroll in their plans. Most Medicare enrollees have access to at least one such M+C plan, and currently about 1 in 6 beneficiaries have joined one. Medicare will pay some or all of the monthly M+C plan premium, and enrollees pay the remainder. Plans generally must cover all Medicare services and generally must be open to all people eligible for Medicare (except those with end-stage renal disease). In most M+C plans, enrollees can only go to doctors, specialists, or hospitals on the plan's approved network. But most plans impose little or no coinsurance and some M+C plans cover extras like prescription drugs. Generally, M+C enrollees face lower overall costs than under fee-for-service Medicare.

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[3]The Board of Trustees reports annually on the status of program income and outlays. To view the complete report, visit the HCFA Website http://www.hcfa.gov under the "Stats & Data" button, or the Social Security Administration's Website http://www.ssa.gov.

PRIORITIES AND ACCOMPLISHMENTS IN 1999

In addition to the National Medicare Education Program, HCFA staff focused on five areas of Medicare in 1999.

Promoting preventive care

One of the more significant improvements in the Medicare program over the past few years, enhanced by passage of the BBA, was the expansion of preventive services. The BBA created four classes of covered preventive services: annual screening mammography for all women age 40 and over; screening pap smear and pelvic exams every 3 years; colorectal screening; and bone mass measurements to identify bone mass, detect bone loss, or determine bone quality. The BBA also created a benefit for prostate cancer screening, but that benefit is scheduled to be implemented later than the others. The BBA also extended through FY2002 the influenza and pneumococcal vaccination campaign conducted by HCFA in conjunction with the Centers for Disease Control and Prevention (CDC) and the National Coalition for Adult Immunization.

As a result of aggressive outreach campaigns, use of Medicare's prevention benefits has increased steadily. Data from a survey of beneficiaries shows these trends through 1998; claims data, although excluding beneficiaries enrolled in managed care organizations, indicate increases from 1998 to 1999 as well.

HCFA has developed a strategy called "Healthy Aging" to study preventive actions that can improve the health and quality of

Use of Selected Preventive Services* by Medicare Beneficiaries, 1994-1998

Service	1995	1996	1997	1998
	Beneficiaries Who Received Service, as a Percentage of All Beneficiaries			
Mammogram**	39.6	41.7	42.7	45.9
Pap smear**	39.0	42.2	42.0	42.7
Flu shot	57.3	61.3	64.0	65.6
Pneumonia shot***	33.6	43.0	48.8	54.0

NOTES:
* Comparable data for other preventive services will be available for 2000.
** Figures reflect percentages of female beneficiaries.
*** Because pneumonia vaccination is generally recommended once in a lifetime, figures reflect cumulative percentage of beneficiaries

SOURCE: Medicare Current Beneficiary Survey. Data are self-reported and cover aged and disabled beneficiaries, including those in managed care and fee-for-service. Because they are self-reported, data may include both screening and diagnostic services received.

life of aging Medicare beneficiaries. The Healthy Aging project will use the best science available to identify what works to promote health and delay functional decline in older populations.

Helping providers understand Medicare

During 1999, we expanded our national education program to help physicians and other health care professionals better understand Medicare's billing procedures. This expansion effort incorporated new technologies to better deliver HCFA's messages to targeted health care professionals. Our $1.3 million training program features interactive computer-based training modules, satellite broadcasts, a provider education web site, and a comprehensive educational program developed for physicians who are new to the Medicare program, such as medical residents. The scope of our national education program also expanded to include health promotion and disease prevention, as well as a coordinated provider customer service initiative.

Improving Medicare service delivery and payment

The BBA instituted one of the most sweeping sets of changes to Medicare since the program's inception. The law literally made hundreds of changes to the program, and a significant amount of HCFA's staff resources were devoted to implementing these changes.

In addition to the sheer volume of the changes, the implementation schedule was complicated by our need to make computer systems ready for January 2000. Because of the need to "freeze" payment and eligibility systems so that Y2K changes could be tested, we had to defer introduction of many program changes until after the Y2K threat had passed. However, significant progress was made even on those parts of the BBA that were delayed.

Payment systems. In 1999, HCFA made substantial progress in implementing new prospective payment systems for skilled nursing facilities, outpatient hospital departments, and home health care that provide incentives to provide care efficiently.

* In July 1999, we published a final rule implementing BBA provisions regarding Medicare payment for skilled nursing facility services. This legislation established a prospective payment system, a consolidated billing provision, and a number of related changes.

* We completed work on a final regulation implementing a new Medicare payment system for hospital outpatient services. The new system is designed to ensure the program and its beneficiaries pay appropriately for services and to encourage more efficient delivery of care.

* In 1999, we published a proposed rule for a home health prospective payment system that replaces the interim system put in place by the BBA. Under the system, which applies to all home health agencies, Medicare will pay home health agencies a predetermined base payment adjusted for the health condition and care needs of the beneficiary, as well as geographic wage differences.

Demonstrations. One of the ways in which we engage in continual improvement of the Medicare program is through the use

of demonstration authority. Through this authority, we operate projects that test the effect of changes in payment mechanisms on a limited scale. Some of the demonstrations are mandated specifically in legislation, others are initiated internally by HCFA staff, and stakeholders in our programs suggest others.

During 1999, more than thirty demonstrations were operational or under development. These projects spanned a wide range of interests, including contracting for durable medical equipment by competitive bidding, testing a broad range of managed care delivery system options, applying managed care methods to fee-for-service care, and combining Medicaid and Medicare services for nursing-home eligible beneficiaries into a single capitated arrangement. For a full description of Medicare demonstration projects under way in 1999, visit our Website at http://www.hcfa.gov under the "Research & Demonstrations" button.

Improving quality of care

HCFA is working to improve the quality of health care. We are doing this by:

* Developing and enforcing standards and surveillance;
* Measuring and improving outcomes of care;
* Educating health care providers about quality improvement opportunities; and
* Educating beneficiaries to make good health care choices.

We are using performance measurement to achieve the Agency's goals of: 1) providing consumer information that assists beneficiaries in making choices in health care, 2) setting process and outcome criteria to which plans and providers are held accountable, and 3) facilitating quality improvement activities.

The science of quality measurement has evolved during the past five years. In collaboration with other health care purchasers, we developed and put into use new measures of health care outcomes. Currently, HCFA initiatives include the Health Plan Employer Data and Information Set (HEDIS) for measuring quality, access, and utilization of Medicare managed care organizations; the CAHPS for measuring beneficiary satisfaction with managed care organizations and fee-for-service plans; the Medicare Health Outcomes Survey (HOS) for evaluating the functional status of beneficiaries; End Stage Renal Disease Clinical Performance Measures (CPM) for determining the quality of services in renal dialysis facilities; the Hospital Core Performance Measure Set; Minimum Data Set (MDS) Quality Indicators for Nursing Homes; and the Outcomes and Assessment Information Set (OASIS), which is a clinical data set designed specifically to develop outcome based quality indicators for home health care.

The Medicare Coverage Advisory Committee. In 1999, we instituted a new method of determining which services should be covered by Medicare. Until now, most Medicare coverage and policy decisions have been made locally by HCFA contractors — the private companies that by law process and pay Medicare claims. The Agency also makes coverage policies that apply nationwide and are binding on all contractors and administrative law judges (who hear beneficiary appeals of denied coverage). Under the new administrative

process, we will initiate coverage reviews when appropriate and accept formal requests from external parties for coverage decisions.

To assist us in this process, we have created a Medicare Coverage Advisory Committee (MCAC) — a group of experts who will advise Medicare on coverage policy decisions. The MCAC is comprised of an Executive Committee and six panels that roughly parallel Medicare benefit categories. The expertise of the MCAC members will assist us in making timely, science-based coverage decisions using a new administrative process that is easily understood and open to the public. During 1999, we completed the process of appointing members, and held four meetings.

Further information about the MCAC, and the meeting schedule for 2000, can be found at http://www.hcfa.gov/quality/adv-mcac.htm.

Peer Review Organizations (PROs). The PRO program consists of a national network of 53 contracts (one in each State, the District of Columbia, Puerto Rico, and the Virgin Islands) whose mission is to ensure the quality, effectiveness, efficiency, and economy of health care services provided to Medicare beneficiaries. The program has three objectives:

* To improve quality of care by ensuring that beneficiary care meets professionally recognized standards of health care;
* To protect the integrity of the Medicare Trust Fund by ensuring that Medicare only pays for services and items that are reasonable and medically necessary and that are provided in the most economical setting;
* To protect beneficiaries by expeditiously addressing individual beneficiary complaints, hospital issued notices of noncoverage, complaints of hospital "dumping," and by carrying out other statutory responsibilities.

PROs operate under three year contract cycles. In 1999, HCFA began the sixth cycle, referred to as the PRO 6th Scope of Work (SOW). Under the 6th SOW, PROs, through their Health Care Quality Improvement Program (HCQIP), are continuing to refine their quality improvement approaches to address the first objective listed above. They are focussing on six clinical areas, selected for their public health importance and for the feasibility of measuring and improving quality: acute myocardial infarction, breast cancer, diabetes, heart failure, pneumonia, and stroke.

Collaboration and partnership are critical components to the success of the HCQIP. The PRO projects represent an historic opportunity to work with practitioners, providers, plans, other purchasers, and beneficiaries to:

* Develop quality indicators firmly based in science;
* Identify opportunities to improve care through careful measurement of patterns of care;
* Communicate with professional and provider communities about these patterns of care;
* Intervene to foster quality improvement through system improvements; and

* Remeasure to evaluate success and redirect efforts.

Each PRO will also conduct at least one project in an alternate setting of care, and one project focusing on a defined disadvantaged population. PROs will also assist managed care plans with their quality improvement efforts.

The PROs employ physicians, nurses, health care quality professionals, epidemiologists, statisticians, and communication experts to accomplish their quality improvement work. Because they are funded by the Medicare Trust Fund, PROs do not charge partners or collaborators for their services.

Health care professionals, providers, and national and local organizations are encouraged to adopt HCQIP priorities and to work with the PROs to foster improvement activities to improve care for all patients, regardless or age, payor, or setting of care. Providers will achieve a higher quality of care and improve outcomes for individuals across the nation by working in partnership with HCFA and the PROs.

In addition to focusing on quality improvement in the clinical areas mentioned above, the 6th SOW holds PROs accountable for initiating a Payment Error Prevention Program (PEPP). The purpose of PEPP is to reduce the occurrence of payment errors in the Medicare Program. PROs must also provide beneficiary protection and education through mandatory case review (including review of beneficiary complaints) as a part of their 6th SOW responsibilities.

For more information on HCFA's Quality of Care Project Activities, visit our Website at http://www.hcfa.gov/quality/3.htm. For more information about the PRO Program, visit http://www.hcfa.gov/quality/5b.htm.

Value-based purchasing

The convergence of payment reform and quality initiatives results in the concept of "value-based purchasing." We have long been a leader in developing effective information systems to support payment policies, quality improvement efforts and health services research. We are now using that information to become a more value-based purchaser of health care: aggressively pursuing high quality care for beneficiaries at a reasonable cost.

To purchase health care based on quality as well as cost, and to advocate for quality of care on behalf of its constituents, we are implementing specific functional elements of value-based purchasing:

* setting priorities related to cost, quality and desired outcomes;
* selecting purchasing strategies accordingly;
* adopting performance measures to validate results;
* collecting and analyzing appropriate data; and
* identifying and implementing improvement opportunities through enforcement of performance standards, technical assistance to plans and providers, education and assistance to consumers, payment, grant and coverage policies that match policy goals, collaborating with other purchasers and rewarding desired performances.

Research is a part of the ongoing process, to help determine what strategies work and

the most effective ways to translate and disseminate information on "best practices."

GUARANTEEING HEALTH CARE ACCESS FOR AMERICA'S VULNERABLE AND POOR POPULATIONS: MEDICAID

Medicaid pays for medical assistance for certain individuals and families with low incomes and resources, and is the largest program paying for medical and health-related services for America's poorest people. It is a jointly funded cooperative venture between the Federal and State governments. Within broad national guidelines provided by the Federal Government, each State establishes its own eligibility standards; determines the type, amount, duration, and scope of services; sets the rate of payment for services; and administers its own program. Thus, the Medicaid program varies considerably from State to State, as well as within each State over time.

In FY1999, combined State and Federal spending on the Medicaid program was more than $190 billion. Of that amount, $181 billion was for "medical assistance payments," including direct payments to providers of care and capitation payments to managed care organizations. The remaining $9 billion was spent for program administration.

Initially, Medicaid was a medical care extension of federally funded income maintenance programs for the poor, with an emphasis on the aged, the disabled and dependent children and their mothers. Over time, however, Medicaid has diverged from that original tie to cash assistance programs. Recent legislation expands Medicaid coverage to people (low-income pregnant women, poor children, and some Medicare beneficiaries) who are not eligible for any cash assistance program and who would not have been eligible for Medicaid under earlier rules. Other legislation has expanded the groups to whom States may choose to offer Medicaid and still receive Federal matching funds.

In addition to coverage expansions, another significant development in the Medicaid program since its inception has been its transition from a fee-for-service program to one that relies upon managed care arrangements to deliver care to more than half of its recipients nationwide. With these managed care arrangements, State governments face a more predictable program cost, and beneficiaries gain access to more stable and consistent sources of health care.

Priorities and accomplishments in 1999

Recent changes in the Medicaid program provided the focus for our activities in 1999. The BBA establishment of new classes of Medicare enrollees eligible for Medicaid benefits, coupled with analysis of use of existing classes of eligibility, suggested the need for considerable outreach. A similar need was created by the "de-linking" of Medicaid eligibility from cash assistance programs, and the de-linking also posed challenges to data systems' ability to maintain accurate eligibility rolls. We worked to implement changes brought about by the Supreme Court's decision in Olmstead v. L.C., a court case that changed significantly the role of institutional care in the provision of services to Medicaid beneficiaries. And we continued to work with States on innovative ways to deliver and pay for Medicaid services.

Reaching out to people with dual (Medicare and Medicaid) eligibility

The Congress has created a number of Medicaid features designed to ease the financial burden of Medicare premiums and coinsurance on low-income enrollees. Efforts such as the Specified Low-income Medicare Beneficiary (SLMB) and Qualifying Medicare Beneficiary (QMB) programs have been in existence for years, and new programs were created by the BBA. But many people who are eligible do not take advantage of the programs. To address this issue of underenrollment, we and our partners undertook a multi-phase campaign to reach potential beneficiaries.

Enrollment Target. We worked with States to establish national and/or individual State baselines and enrollment targets upon which performance in FY2000 and beyond can be judged. Although we have established a national enrollment target, we will monitor the contribution of each State in the achievement of this goal through an examination of State specific data. If a State's enrollment is not comparable to the national target, a State-specific goal may be set for FY2001.

Outreach Kit. We developed a Dual Eligible Outreach Kit containing outreach and enrollment material that can be quickly customized by stakeholders at minimum expense. The kit is available at http://www.nmep.org or http://www.medicare.gov/nmep.

Resource Guide. In addition to the Outreach Kit, we created an interactive Dual Eligible Resource Guide and SCHIP Resource Guide for use in designing outreach and enrollment campaigns for the dual eligible and SCHIP populations. The Guide (covering both populations) is available at http://www.nmep.org or http://www.medicare.gov/nmep.

Regional Training Sessions. HCFA, the Social Security Administration (SSA), and the Health Resources and Services Administration are jointly sponsoring five regional training sessions on dual eligible partnership opportunities and social marketing techniques that can be employed in outreach and enrollment campaigns for the dual eligible population.

Print Projects. In July 1999, HCFA made funds available to States, working in partnership with local beneficiary groups, either to conduct a targeted mailing of shortened mail-in applications or to print and supply sufficient amounts of materials needed for outreach to potential dual eligibles to local community groups (or both).

Website. HCFA's new Dual Eligible web page at http://www.hcfa.gov/medicaid/dehmpg.htm became active in April 1999. The Website serves as a resource for beneficiaries and as a clearinghouse of information for individuals working with the dual eligible population.

SSA Demonstration. HCFA worked with SSA on the design of a demonstration to test various models of SSA participation in the enrollment process for dual eligibles. The demonstration was implemented in seven States beginning in March 1999.

Direct Outreach. In January 1999, potentially eligible Medicare beneficiaries in New York, Michigan, and Texas received a "Good News" letter and a brochure from HCFA, describing dually eligible options.

We worked closely with these three States to pilot test new print materials and hired a contractor to evaluate the effectiveness of the project.

As part of a FY2000 and FY2001 GPRA measure, we will continue to facilitate and support partnership development at the State/community level through technical assistance, training, and tool development. Additionally, we will set enrollment targets and will work to refine the Leads Data that is currently used to identify potential beneficiaries, and we will explore other data sources that could be used to identify potential beneficiaries.

Delinking Medicaid and Temporary Assistance for Needy Families (TANF)

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) has enabled States to expand health care coverage eligibility and help more low-income people make the transition from welfare to work. While PRWORA broke the link between cash assistance programs and eligibility for Medicaid, it also explicitly guaranteed that children and families who would have qualified for Medicaid through receipt of cash assistance would continue to be eligible for Medicaid.

Overall national statistics on Medicaid enrollment are encouraging, but there is variation among States. The most recent statistics show that total Medicaid enrollment is about the same now as it was before welfare reform. However, we know that many eligible families are not enrolled, and we are concerned about instances in which State practices have resulted in eligible individuals losing health care coverage.

We have taken a series of actions to ensure that States comply with the PRWORA and address its impact on Medicaid enrollment. Most recently, we instructed all States to review Medicaid terminations and re-enroll improperly terminated individuals. We also asked States to ensure that their computer systems and eligibility processes have been modified so that families eligible for Medicaid do not inappropriately lose coverage when their eligibility for cash assistance ends.

We have taken and are continuing to take several steps to help States adjust to the changes and address specific situations in which eligible individuals were denied Medicaid coverage. We are working with States to find new ways to reach children and families outside, as well as through, the welfare system. Our efforts to help States address these types of concerns began shortly after the PRWORA was enacted.

Helping States ensure that all eligible individuals are enrolled in Medicaid and SCHIP is an integral part of making welfare reform work. Health care coverage is critical in helping families work towards self-sufficiency. Many States are addressing the challenges associated with changing eligibility rules and systems, and some have developed promising new strategies for ensuring that children and families who are not receiving cash assistance are properly evaluated for Medicaid eligibility.

Ticket to Work

During 1999, HCFA's Office of Legislation worked extensively in the legislative development of the health provisions of the Ticket to Work and Work Incentives Improvement Act of 1999 (TWWIIA). This Act, which offers

Medicaid eligibility to working individuals with disabilities and establishes two new HCFA grant programs worth more than $400 million over the first six years, was signed into law in December 1999. As a result, during FY2000, we will face the challenges of implementing TWWIIA, adding significantly to the multitude of activities managed by the Agency.

The *Olmstead* decision: Assuring access to community living for the disabled

In June 1999, in *Olmstead v. L. C.*, the U.S. Supreme Court ruled that under the Americans With Disabilities Act (ADA), unjustifiable institutionalization of a person with a disability who (with proper support) can live in the community, is discrimination. The Court said that States are obliged to "make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability, unless the public entity can demonstrate that making the modifications would fundamentally alter the nature of the service, program or activity."

In accordance with that Court ruling, we developed guidelines for State Medicaid directors on how to make their programs responsive to the desires of disabled persons to live in appropriate community-based settings. In our guidance letter to State Medicaid Directors, we reminded States that they have an obligation under Medicaid to periodically review the services of all residents in Medicaid-funded institutions. The letter also reminded States that they may choose to utilize their Medicaid funds to provide appropriate services in a range of settings from institutions to fully integrated community support. We urged States to develop comprehensive working plans to strengthen community service systems and to actively involve people with disabilities and their families in the design, development and implementation of such plans. We also encouraged States to take steps to prevent future inappropriate institutionalization of persons with disabilities and to assure the availability of community-based services.

In addition to continued technical assistance to States, we will review relevant Federal Medicaid regulations, policies and previous guidance to assure that they are compatible with requirements of the ADA and *Olmstead* decision and that they facilitate States' efforts to comply with the law.

Demonstrations

As with Medicare, we have found that demonstration projects are a valuable way to test new payment, delivery, and coverage models. In the case of Medicaid, program changes are tested under waivers of program rules. HCFA has the authority under various sections of the Social Security Act to grant a waiver of Medicaid rules to a State in order to allow experimentation with eligibility expansions, benefit packages, or delivery systems. In 1999, nearly 20 States had large-scale demonstrations with waivers in place to allow experimentation in these areas.[4] Aside from the waivers associated with these large demonstrations, almost every State in the Union and the District of

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[4] We meet our fiduciary obligations by requiring that the demonstrations be budget neutral: a State's expenditures under the demonstration shall be no more than they would have been without the demonstration.

Columbia has some form of waiver authority in place.

PROMOTING HEALTH CARE QUALITY AND INSURANCE SECURITY FOR ALL AMERICANS: SURVEY AND CERTIFICATION, CLIA, AND HIPAA

Through our survey and certification of health care facilities, our regulation of the clinical laboratory industry, and our activities under the Health Insurance Portability and Accountability Act, we affect the health care received by practically every American.

Survey and Certification

The State Survey and Certification program ensures that entities providing health care services to Medicare and Medicaid beneficiaries meet Federal health, safety, and quality standards. Entities covered include hospitals, nursing homes, home health agencies, end-stage renal disease facilities, hospices, and many other facilities serving Medicare and Medicaid beneficiaries. We contract with survey agencies in each State to perform initial inspections of providers who request participation in the Medicare program and to perform periodic recertification of health care providers. Staff from HCFA's Central and Regional Offices provide training and monitor the consistency and quality of State surveys.

Compliance with the Medicare conditions of participation can also be demonstrated through accreditation by a national accrediting body whose standards and survey process have been determined to be as stringent as HCFA's requirements. We monitor the performance of accreditation organizations and the continued equivalence of their standards using documentation and notification requirements, comparability reviews, surveys (or inspections) of accredited providers conducted by State survey agency or Federal surveyors, and on-site reviews.

The Nursing Home Initiative

HCFA's July 1998 Report to Congress on the effectiveness of the current system of survey and certification in nursing homes nationally suggested that we needed to do more to improve the care that residents receive. In 1999, we continued to implement the following activities:

* focusing on preventing bedsores, malnutrition and resident abuse by increasing the survey sample size of residents, ensuring that facilities have an abuse prevention system, placing a repository of best practice guidelines for at-risk residents on HCFA's Website and launching related educational campaigns;
* staggering or otherwise varying the scheduling of surveys to reduce the predictability of surveyor visits;
* taking faster action to sanction a facility found to have serious noncompliance, or when it has a history of termination from our programs, or any other time when HCFA or the State believes immediate action is warranted;
* inspecting problem facilities twice as often (with no decrease in inspections of other facilities), so that persistent problems can be addressed quickly;
* collecting fines of up to $10,000 from facilities when single deficient practices

have been found or deficient events have occurred;

* requiring that complaints alleging harm to residents be investigated within 10 days;
* posting survey results on the Internet; and
* implementing the Minimum Data Set (MDS) and related systems, which support the prospective payment system for skilled nursing facilities and the development of quality indicators for nursing home residents.

Nursing home chain bankruptcies

In 1999, two of the 10 largest national nursing home chains — Sun and Vencor — filed for Chapter 11 bankruptcy protection (and two more — Mariner and IHS — filed early in 2000). In the fall of 1999, we established a protocol to monitor the quality of care and quality of life for residents of facilities of these chains.

Issues related to Intermediate Care Facilities for the Mentally Retarded (ICFs/MR)

In response to a news report that some of the deaths of people with developmental disabilities living in Group Homes in the District of Columbia between 1993 and 1999 resulted from abuse, neglect and or mistreatment, we conducted Federal surveys of 10 percent of the District's ICFs/MR. We found that 10 of the 13 facilities surveyed were out of compliance with program requirements. In addition, three facilities were found to have situations in which the provider's noncompliance caused, or is likely to cause, serious injury, harm, impairment or death to a resident.

Several actions were planned in order to deal with this situation in the District and nationally. The District was required to develop a Corrective Action Plan to address immediate protection of beneficiaries, as well as how to plan for long term systemic correction. In addition, the remaining 122 facilities are to be surveyed, and we will continue to work with the District to monitor corrective actions and increase accountability. We are in the process of drafting a proposed rule to change the conditions under which ICFs/MR participate in our programs, which we hope to publish in the fall of 2000.

Implementing the Clinical Laboratory Improvement Amendments

Congress passed the Clinical Laboratory Improvement Amendments (CLIA) in 1988 to ensure the accuracy, reliability and timeliness of patient test results regardless of where the tests were performed. HCFA is charged with the implementation of CLIA, including laboratory registration, fee collection, surveys, surveyor guidelines and training, enforcement, approval of proficiency testing providers (entities that test the diagnostic ability of labs), accrediting organizations and exempt States. The Centers for Disease Control and Prevention (CDC) is responsible for test categorization and for evaluation of the program's effectiveness.

The bulk of our activity in 1999 involved work with the CDC to develop a final CLIA rule that reflects all comments received and new technologies that have emerged since the interim rule was published in 1992. During 1999 we also surveyed about 15,000 laboratories, and accrediting agencies surveyed another 9,000.

For more information about the CLIA program, visit our Website at http://www.hcfa.gov/medicaid/clia/cliahome.htm.

Implementing the Health Insurance Portability and Accountability Act

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is designed in part to protect health insurance coverage for workers and their families when they change or lose their jobs. Responsibility for implementing HIPAA lies with the Departments of Health and Human Services (DHHS), Labor, and Treasury. The Act includes provisions that limit exclusions for preexisting conditions; that prohibit employers and insurers from discriminating against employees and dependents based on their health status; and that guarantee renewability and availability of health coverage to certain employees and individuals in both the individual and group health insurance markets.

Over time, Congress has added other parts to the HIPAA statute. New protections were for individuals who elect breast reconstruction in connection with a mastectomy, and for mothers and their newborns with regard to hospital lengths of stay following childbirth. Provisions were added providing that insurance issued to group health plans with more than 50 employees that provide both medical/surgical benefits and mental health benefits may not impose an aggregate lifetime dollar limit or annual dollar limit on mental health benefits that is less than such a limit on medical/surgical benefits.

The "Administrative Simplification" provisions of HIPAA direct DHHS to adopt national electronic standards for automated transfer of certain health care data between health care payers, plans and providers. HIPAA seeks to simplify and encourage the electronic transfer of data by replacing the many nonstandard formats currently used nationally, with a single set of electronic standards that would be used throughout the health care industry. HIPAA also requires the establishment of standards for the security of electronic patient information in computer systems throughout the health care industry. HCFA is leading the development of these standards.

Insurance markets

Policy. We spent 1999 working intensively on regulations needed to implement provisions of HIPAA, culminating a three-year effort to craft a joint rule that implements changes to the Public Health Service Act, ERISA, and the Internal Revenue Code. We also made substantial progress toward completing the final regulation on the HIPAA provisions relating to preexisting condition exclusions, special enrollment, and related rules.

Monitoring and enforcement. We completed review of States' ability to substantially enforce HIPAA related provisions. Finding 21 States that appear to have enacted no law with respect to one, two or all three HIPAA related provisions, we are preparing to directly enforce HIPAA related provisions in States that do not have or do not quickly enact appropriate laws. We also completed an analysis of State laws with regard to provisions in the initial HIPAA legislation and began the process of focusing on potential problems with key provisions in individual States in order to determine whether those potential problems represent a failure to "substantially enforce" such provisions.

We have also engaged in market examinations. In those States where we are responsible for direct enforcement of the insurance reform provisions, we are conducting reviews of insurance carrier procedures and practices.

Outreach and Education. Because HIPAA is little known and little understood, we felt it was important to focus on outreach and education. We held an advocacy and outreach conference in April 1999 to help us identify better tools for making the public aware of HIPAA and the protections it provides. We developed a consumer-oriented Website at http://www.hcfa.gov/medicaid/hipaa/default.asp to help individuals understand their insurance options and rights under HIPAA. We also developed and distributed informational brochures for the individual and group markets.

For further information on the insurance aspects of HIPAA, visit our Website http://www.hcfa.gov/medicaid/hipaa/default.asp.

Administrative Simplification

Proposed rules related to transactions and coding, a National Provider Identifier, a National Employer Identifier, and security were published in 1998, and a proposed rule related to privacy was published in November 1999. We hope to have final rules for these parts of administrative simplification toward the end of CY2000. Proposed rules for a National Health Plan Identifier and for claims attachments are still in development, and the rule for a National Individual Identifier is on hold pending the completion of the Privacy regulation in the fall of 2000.

For further details about the administrative simplification aspects of HIPAA, visit Websites http://aspe.os.dhhs.gov/admnsimp/ and http://www.hcfa.gov/medicare/edi/edi.htm.

CHALLENGES FOR THE COMING YEAR

Although we are proud of what we accomplished during 1999, it is clear that much remains to be done. We live in a world in which economic, social, demographic, and technological forces are in a continual state of change, and we must be not only prepared to react to changes but to anticipate them. Even in the absence of change, there is always room for us to improve upon our performance.

The Department's Office of Inspector General (OIG) and the General Accounting Office (GAO) each have responsibilities for evaluating our performance. Through testimony, audits and reports, they have commented on specific aspects of our activity during the past year. We share their concern that our programs be administered in a prudent, responsible, and accountable way, to minimize the threat of wasteful or fraudulent spending and maximize the responsiveness of those programs to the needs of beneficiaries.

The GAO issued 61 reports in FY1999 related to HCFA and its programs. They spoke and wrote of the "unprecedented set of challenges" that HCFA was facing, among which were the substantial new authorities and programmatic responsibilities added by BBA, HIPAA, and BBRA to HCFA's ongoing management of Medicare and Medicaid. GAO auditors have reported on the immediacy and resource demands associated with meeting Y2K computer systems, financial management and Medicare fee for service claims administration; as well as the issue of HCFA's aging workforce.

GAO reports generally addressed two broad sets of issues: coverage and outreach, and program management. In addition, considerable GAO oversight and testimony was devoted to HCFA's activities related to the Y2K problem. In terms of coverage and outreach, GAO reports covered a wide range of issues. Some related to the effectiveness of programs in reaching target populations. Others addressed managed care issues. Still others dealt with potential coverage or program expansion.

For a complete listing of GAO reports and testimony related to HCFA and our programs, visit the GAO Website at http://www.gao.gov.

The OIG also has reported a number of concerns regarding HCFA and its programs. These concerns fall into a number of broad areas.

* Financial control issues, such as misuse of contractor funds and weaknesses in financial systems and claims processing;
* Payment issues, such as excessive reimbursement for equipment and supplies and spending for medically unnecessary and incorrectly coded services.
* Implementation of Balanced Budget Act provisions, especially delayed reforms, such as consolidated billing in nursing homes, home health prospective payments, and the ambulance fee schedule.

* Quality of care in nursing homes, including bed sores, accidents, and nutrition problems.

For more on the OIG and its interactions with HCFA, visit the OIG Website at http://www.hhs.gov/progorg/oig/.)

We concur with many of the concerns raised by the GAO and by OIG. We hope to work with Congress to address the legislative obstacles to nimble and prudent program management, and we are working diligently to address those issues for which resolution is under our control. Where we differ with the GAO or the OIG regarding the severity of some of their concerns, we will work with them to resolve our differences.

All of our activities are infused with a heightened awareness of change in the larger health care environment in which we operate, and of the need for flexible responses to those changes. In the years ahead, HCFA will need to carry out its mandate to ensure access to high quality health care for the elderly, persons with disabilities, and certain low-income populations in this changing environment.

Combining our concerns with those of OIG and GAO, we have developed a set of goals for the coming year to do just that.

Fight Fraud and Abuse

This is our top priority, and our plans were described earlier in this report. We are taking several new steps to further protect Medicare's financial integrity and bring the claims payment error rate down. Key among these are efforts to determine an error rate for every contractor that pays these claims, and efforts to help providers document and file claims correctly.

We also can expect to see more impact from the many program integrity efforts that we initiated this past year through our comprehensive program integrity plan and other steps. We hired special contractors to focus solely on preventing improper payments. We greatly strengthened contractor oversight through tighter performance evaluation standards, national evaluation teams, and mandatory corrective action plans. And we continue to seek contracting reform legislation so we can use the same contracting rules as other government agencies and expand the range of firms capable of serving Medicare and protecting taxpayer dollars.

We are aggressively addressing financial management issues identified by us, the OIG, GAO, and independent accounting firms with which we have contracted. Most of these issues have their roots in the system established in the 1965 Medicare law, whereby Medicare must contract with private health insurance companies to process and pay claims. We have made significant progress, and we have an ambitious array of actions already planned or underway that are consistent with the GAO report's recommendations. We are determined that Medicare and its contractors meet the same high standards of accounting required of major private sector corporations.

Improve Oversight, Management and Accountability

Our second priority is improving oversight, with a special focus on Medicare contractors and State survey and certification programs. Problems with health care quality in many nursing homes have led to changes in how HCFA monitors nursing

homes, including targeting those with problems for more vigorous oversight.

Other goals in this area include fighting fraud and abuse, reducing payment errors in the Medicare program, achieving agency goals under GPRA, and completing the implementation of recent legislation.

Improve Responsiveness to Congress and the Public

For example, we will work to improve the National Medicare Education Program which informs Medicare beneficiaries about their health plan choices. We are streamlining the process for responding to inquiries received in our central office. And we are implementing toll-free numbers for providers to call with their questions about Medicare coverage and payments.

Enhance Beneficiary Focus

HCFA will continue to work with the States to address Medicaid enrollment issues that have surfaced as a result of welfare reform. We will also work with States to expand community-based care for people with disabilities as a result of the Olmstead court case. We will work with States to improve SCHIP outreach to eligible families. And we will work to improve quality through the medical error reporting initiatives.

Develop Strategies for the Future

We will publish the Medicare coverage criteria and institutionalize the new Medicare coverage advisory committee process. We will provide leadership for Medicare modernization, including the new Medicare outpatient prescription drug benefit and market-based approaches to purchasing. We will conduct research on the next generation of payment methodologies. And we will improve the security of information systems.

About 40 percent of HCFA staff are expected to retire within the next 10 years; the agency will need to focus on recruiting new staff and improving the retention and training of existing staff through career development activities. We have prepared a five year HCFA-wide strategic plan for human resources that includes HCFA's human resources mission, vision, operating principles, performance goals and strategies, and a methodology for administering the plan. We are in the process of sharing the HR plan with our stakeholders, and we are preparing operating plans to specify the actions needed to meet our performance goals.

HCFA as an Organization

The Health Care Financing Administration (HCFA) was created in 1977 to bring together, under one leadership, the two largest Federal health care programs — Medicare and Medicaid. With the creation of HCFA, certain administrative and programmatic efficiencies were anticipated, such as the opportunity to establish uniform conditions of participation for facilities under both Medicare and Medicaid.

During the two decades since HCFA was established, the Agency's statutory mission has grown beyond administration of Medicare and Medicaid. It now includes responsibility for Federal oversight of clinical laboratories, oversight of Medigap insurance, and individual and small group market health insurance regulation. In addition, HCFA now administers SCHIP, to expand health insurance coverage to low-income children.

HCFA accomplishes its mission by working with and through others. Capable as they are, our employees are only a small portion of a large, complex network that makes our programs work successfully. HCFA employees, HCFA agents, other DHHS Agencies, other Federal Agencies, States, territories and Tribes, providers of care, beneficiary and consumer organizations, accrediting bodies, researchers, and others work together to help ensure that our beneficiaries have access to high quality care. Our ability to accomplish many of our strategic goals and objectives and performance goals is intricately related to and dependent upon the performance of different components in this complex network.

Our operating principles call for us to become a "nimble" organization, and internal assessments suggest that we have made progress in that direction. In 1999, HCFA was one of 46 agencies to participate in a survey of Federal employees conducted by the National Partnership for Reinventing Government (NPR) and the Office of Personnel Management. The NPR survey assesses large agency organizational changes, especially in relation to their efforts to reinvent their operations. It helps us to identify areas where we may need to improve to better serve our customers and employees and improve our overall operations.

The 1999 results for HCFA were extremely positive and show that we as an organization made significant progress during the year. Employees reported greater satisfaction in the areas of teamwork, working collaboratively with our union partners, increasing the attention and resources devoted to employee rewards and recognition and employee training and development, and addressing job satisfaction-related concerns (i.e., quality of worklife and flexibility to accomplish mission results). However, there is still progress to be made in these important areas. We have developed a 1999 Improvement Strategy, in which we will focus on employee training and development and on employee performance — more specifically, ensuring that our employees understand what we expect of them in

relation to our mission, and taking corrective action early to assist employees to meet those expectations.

SIZE AND STRUCTURE

Direct Employment at HCFA in Calendar Year 1999

Location	Number of Full- and Part-time Employees
All Locations	**4,623**
Baltimore, MD	2,841
Washington, DC	168
Region I: Boston, MA	150
Region II: New York, NY	162
Region III: Philadelphia, PA	150
Region IV: Atlanta, GA	208
Region V: Chicago, IL	227
Region VI: Dallas, TX	170
Region VII: Kansas City, MO	142
Region VIII: Denver, CO	110
Region IX: San Francisco, CA	177
Region X: Seattle, WA	118

NOTE: Figures are as of December 1999, and translate to 4,364 full-time-equivalents (FTEs).

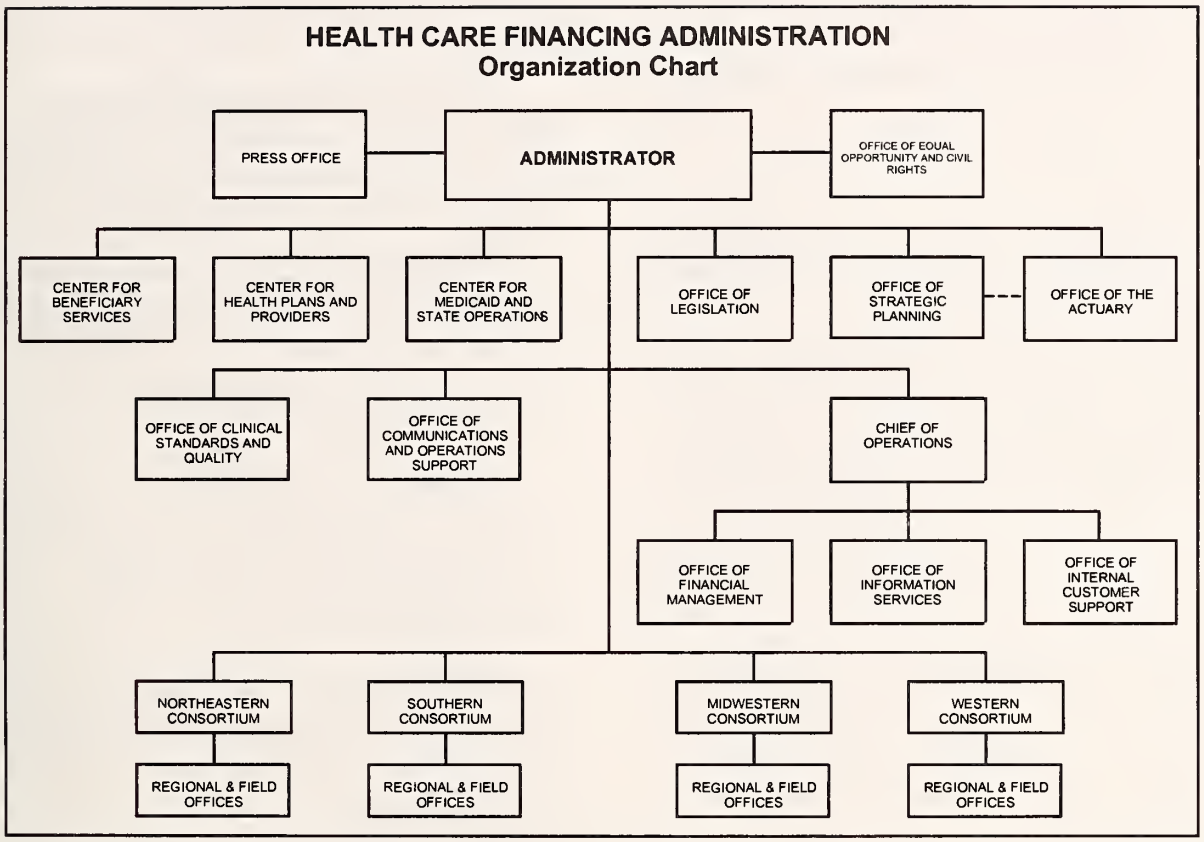
HCFA employs some 4,600 full- and part-time civil servants and members of the Commissioned Corps nationwide. As of December 31, 1999, 2,800 worked in the agency's Central Office, located in Woodlawn, Maryland, about three miles west of Baltimore. The remaining employees were located in the DC office and in our 10 regional offices.

In 1997, we restructured the agency in response to a changing health care environment. The new structure allows us to be more proactive in meeting the needs of our beneficiaries and partners. We met with a broad range of agency customers and stakeholders, and decided that our organizational structural model should be redesigned to better serve HCFA's primary customers. The new model reflects the recognition that the driving force behind current changes in the nation's health care system are not internal to the agency, but external. Using the audience model, HCFA is structured around three external audiences: beneficiaries, health plans and providers, and States.

HCFA's Executive Council is collectively responsible for the successful operation of HCFA programs. Composed of the senior leadership of the agency's various components, it determines the HCFA's program and operational goals and the means of achieving them. It allocates resources throughout the agency within existing legislative constraints. It establishes performance standards and measures of all HCFA programs and monitors the agency's operations to assure that they are being met.

The Center for Beneficiary Services (CBS) is the principal operating component explicitly dedicated to understanding and meeting the needs of its beneficiaries. CBS is also responsible for Medicare contractor management, including leading the development of a long-term contractor strategy to ensure that future Medicare program contracts align with the mission and needs of the agency.

The Center for Health Plans and Providers (CHPP) is responsible for purchasing health care under the Medicare program. It has policy responsibility for defining the Medicare benefits and



establishing the prices to be paid under Medicare for all services. It is also responsible for ensuring that these policies are successfully implemented through claims processing and provider education efforts. This Center plays a key role in managed care payment and oversight.

The Center for Medicaid and State Operations (CMSO) is responsible for program functions involving contact with States. This includes Medicaid and SCHIP policy and operations activities, Medicaid and Medicare survey and certification operations, and activities under CLIA and HIPAA.

The Office of Clinical Standards and Quality (OCSQ) is the component responsible for HCFA policy on clinical coverage issues, technology assessments, clinical quality standards, and conditions of participation. It is also responsible for managing the work of the Peer Review Organizations and End Stage Renal Disease networks.

The Office of Communications and Operations Support (OCOS) is responsible for managing the myriad program operations support activities common to the agency components. This includes such functions as the Executive Secretariat, the clearing and issuing of regulations, preparing manuals and other policy instructions, and coordinating agency correspondence and public affairs.

The Office of Internal Customer Support (OICS) is responsible for planning for and

providing the physical and administrative support the agency needs to operate effectively. This includes the entire range of human resource activities, contracting and grants, facilities management, and administrative services.

The Office of Financial Management (OFM) has the overall responsibility for the agency's financial planning and management activities and the fiscal integrity of HCFA programs. This includes all budget activities, cash management, control of all disbursements, and program integrity operations and enforcement.

The Office of Information Services (OIS), headed by the Chief Information Officer, is responsible for all the major program data and data infrastructure needs of the agency. This includes information resource management planning and oversight, the complete hardware infrastructure, and all central databases.

The Office of Strategic Planning (OSP) is responsible for developing and managing the long-term strategic planning for the agency. OSP staff perform environmental scanning, identifying, evaluating, and reporting emerging trends in health care delivery and financing and their interactions with agency programs.

The Office of Legislation (OL) is responsible for current legislative policy and interactions with Congress and congressional staff.

The Office of the Actuary (OACT) is responsible for actuarial projections and related services, and prepares annual reports to Congress for the Medicare Board of Trustees. Staff prepare various national health statistics, and set Medicare premium and payment rates.

The Office of the General Counsel (OGC) provides a full range of legal services to the Department of Health and Human Services' agencies and its programs.

The Office for Equal Opportunity and Civil Rights (OEOCR) is staffed separately to highlight the agency's commitment to a diverse workforce and equal opportunity for all HCFA employees.

The Press Office, headed by the agency's chief press spokesperson, is responsible for coordinating all external news media contact, through press releases, press inquiries and responses.

Regional activities are formally grouped into four consortia headed by Consortium Administrators who sit on the Executive Council. Regional Offices are responsible for administrating HCFA programs and implementing national policy at the regional level. Each region participates in developing new policy and improving existing policy. Regional Offices serve as principal HCFA contacts for many of HCFA's partners and contractors.

MEDICARE CONTRACTORS

Since the inception of Medicare, HCFA has contracted out the performance of the Medicare program's front-line operational functions to a set of contractors known as the Medicare intermediaries and carriers. In addition to making determinations on Medicare claims, these contractors perform a wide range of related benefit administration functions. At present, there are 33 Medicare intermediaries, including many Blue Cross Blue Shield (BCBS) companies that subcontract through the national BCBS

Association. HCFA contracts directly with the 22 Medicare carriers.

Claims workloads have increased dramatically. For example, carriers processed 721 million claims in FY1999, and fiscal intermediaries processed 147 million claims. These figures are more than double the 347 million and 63 million claims, respectively, processed in FY1989.

At the same time, the unit cost of processing a claim has dropped. This reduction is attributable, in part, to technological advances and to improved business processes (such as the electronic data interchange). But given the rapid pace of change in the nature of the business, we share concerns voiced by GAO that with HCFA running Medicare "on a shoestring ... too great a mismatch between the agency's administrative capacity and its designated mandate could leave HCFA unprepared to handle Medicare's future population growth and medical technology advances."[5]

BUDGET

HCFA's annual budget places it among the largest businesses in the world. With annual costs of $341 billion, our programs channel one out of every three dollars in the U.S. health care market, and our presence influences the other two dollars. Our financing is a mix of premiums, payroll taxes, income tax revenue, and user fees, reflected in tables showing our financial operation in FY1999.

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[5]*Medicare: 21st Century Challenges Prompt Fresh Thinking About Program's Administrative Structure* (GAO/T-HEHS-00-108), May 4, 2000.

HCFA Consolidated Statement of Net Cost Fiscal Year 1999 (Millions of Dollars)				
	Medicare	Medicaid	SCHIP and others	Consolidated Totals
Net Cost of Operations	**184,501**	**109,014**	**537**	**294,052**
Program Costs	200,984	108,896	522	310,402
Medicare Insurance Claims and Indemnities Fee for service	163,626			163,626
Managed Care	37,358			37,358
Medicaid and SCHIP Grants and Subsidies		108,896	522	109,418
Administrative Costs	2,773	116	7	2,896
Personal Services and Benefits	1,284	21	4	1,309
Contractual Services	1,387	87	3	1,477
Other	102	8		110
Bad Debts and Writeoffs	1,533	1		1,534
Other Costs	775	1	147	923
Less: Earned Revenues	21,564		139	21,703
Total Financing Sources	**214,251**	**109,016**	**574**	**323,841**
Appropriations Used	69,846	108,897	522	179,265
Employment Tax Revenue	131,519			131,519
Interest on Trust Fund Investments	12,349			12,349
Other Revenues and Financing Sources	537	119	52	708
Net results of Operations	**29,750**	**2**	**37**	**29,789**
SOURCE: HCFA Financial Report, Fiscal Year 1999				

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